726

Physicians' Costs for Chemotherapy Drugs, November 1992 marked Exhibit Hartman 027 for identification.)
BY MR. EDWARDS:
Q. Dr. Hartman, I have asked the court reporter to mark as Exhibit Hartman 027 a copy of the OIG report on Physicians' Costs for Chemotherapy Drugs dated November 1992.
(Handing Exhibit Hartman 027 to the witness.)
Q. Do you have that report in front of you?
A. I do.
Q. And is this the report that you cite in your declaration?
A. I think that it is.
(Pause.)
(The witness viewing Exhibit Hartman 027.)
A. I am quite sure that it is.
Q. I think you identify it in paragraph 22B on page 16?
A. Right. Yes. I think I -- I do. I

727

don't cite it there, but I have cited it before, so I think this is the same one. I mean I cite it, but I don't have the full citation. I know there is always a number of these studies that they put out, but this looks like the one.
Q. And it is your testimony that this report helped to inform market expectations as to the relationship between ASP and AWP?
A. It summarized what -- what those -- what spreads were and helped inform that relationship, yes.
Q. And it helped inform the market expectation that AWP is larger than ASP by a reasonably predictable amount?
A. For single-source physician-administered drugs, it does -- it did, yes, as I say in that paragraph.
Q. Okay. Why don't you take a look at page 2 of Exhibit Hartman 027. I want to direct your attention to the statement that appears at the top of the page, quote, "Our results indicate that for the physicians surveyed the 13 chemotherapy drugs

728

can be purchased at amounts below AWP and that AWP is not a reliable indicator of the cost of a drug to physicians."
Do you see that?
A. I do.
Q. Does that have any impact on your opinion that the marketplace expected that AWP is larger than ASP by a reasonably predictable amount?
A. By "mine," I take it you mean mine and everyone else that I have cited as comporting with my understanding.
What -- what is being summarized here, it seems to me, is unfocused in that I think the -- one needs to go to the actual data where the amounts are cited, and that is provided in Appendix III, where it lists the invoice costs relative as a percentage of AWP, the invoice cost for branded manufacturers and to oncology wholesalers, and for single-source drugs, what you see there is either under the branded manufacturer, the oncology wholesalers, there is

729

for the single- source drugs, and that was what I'm referring to in that particular paragraph, a fairly -- a fairly tight relationship between AWP and the invoices of the branded manufacturers of the oncology wholesalers that ranges anywhere from 12, what I am seeing here, 12 to 20 percent.
Now there certainly are a few multi-source drugs listed here where the AWP is -- varies more than that, and I'm assuming that is probably what they're referring to, and what -- what I'm -- what I have said here is that I'm looking at single-source drugs, and single-source drugs were at the beginning of the 1990s, the beginning of this damage period, certainly those were the ones that were the most prevalent and what -- what was informing people's opinions about drug relationships, and I think with the drugs in the class in my table 2, I think almost all of them were single source in 1990, 1991, and 1992 when this was done. They became -- several of them became multi-source over the period.
But as Dr. Berndt has said, that the

730

information on the relationship of AWP and ASP for multi-source physician- administered drugs is -- there has been little that really has helped make that very clear, and here is some -- some information, but it's -- it is mostly aimed at some generic drugs, and even some of the generic drugs fall within the -- within the 11 to 20 percent. There is interferon is at 9 to 14 percent on the oncology.

So there are -- there are several multi-source drugs where that relationship deviates from what I am talking about here, but I have focused this on single-source drugs, since that has been the focus of much of the damage period in many of the drugs.

Q. Is it your testimony that a payer reading this report would conclude that multi-source drugs are different from single- source drugs and there is not a predictable relationship between AWP and ASP with respect to multi-source drugs?

A. It's -- it's my opinion that as to

731

physician-administered drugs, private sector third-party payers for the most part look to Medicare and how Medicare was developing its relationships, and the Medpac report confirms that reliance.

So there -- there is some limited information, but in -- as in any kind of market, there is -- pieces of information start to come to light, but they don't -- they don't start to affect expectations for a while. These markets are slow to respond to this, and you see the same thing with the OIG studies of the relationship -- the spreads on self- administered drugs, generics and branded, and they -- they weren't recognizing until later in the '90s that the generic spreads were that large.

So in answer to your question, there is some information here, but it is, as far as I can see from the contracts and everything else, this did not affect what -- how Medicare was ending up setting its reimbursement rates nor how third-party payers were. This was the beginning of an

732

understanding that finally culminated in say 2004 with the Medicare -- with the Prescription Drug Modernization Act.

Q. Well, are you saying that the marketplace had a different expectation for multi-source drugs than it had for single-source drugs?

A. We're talking about physician-administered drugs now; is that right?

Q. Yes.

A. I'm saying that for the -- for the focus of third-party payers negotiating reimbursement rates for different, whether it is for self-administered drugs, whether they are working with their PBMs, whether they are working with providers for physician-administered drugs, that physician-administered drugs was one of the categories of costs that was the smallest speck on the radar screen, and they paid little attention to it, and this is -- this is corroborated or that -- this opinion is certainly put forward by Dr. Berndt, that drugs generally were not on the radar screen. Physician- administered drugs were a much

733

smaller part. And multi-source were even a smaller part of physician-administered drugs going into the 1990s.

So this kind of information, it was starting to pop up, but this was not shaping general expectations as I see in contracts and in revealed preferences from the sources that I have cited.

Q. I believe you testified that it is your testimony that this report is one of the things that informed the market expectations that you found in your analysis; correct?

A. For single-source physician-administered drugs.

Q. So your testimony that a payer reading the language, quote, "AWP is not a reliable indicator of the cost of a drug to physicians," close quote, would conclude that AWP is larger than ASP by a reasonably predictable amount?

A. It is my conclusion that anyone who was a -- that the only person that would read this report and read that one sentence would be --

730

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A. It is my conclusion that anyone who was a -- that the only person that would read this report and read that one sentence would be --

734

would be a lawyer trying to make a point.
This -- someone reading this report would take -- and someone who is focusing on what payers are thinking about, what is going on -- is going to read the whole report, and if it is 1992 and I'm looking at this and I look at all the drugs in our class -- and I am willing to bet that almost all of them were single source in 1991-'92 -- I have got it in a footnote, we can check that, but certainly almost all of them were -- someone looking at this would say ah-ha, you know, in the early '90s physician-administered drugs, a lot of them had not gone generic yet. They were single source. A few did.
What am I looking at here? I am reading the whole thing. I am looking at single- source drugs. Well, this characterizes most of what I'm getting in my claims, and I am looking at what relationships are, and I'm -- that's what I'm seeing.
Q. Do you have any factual basis for concluding that only a lawyer would read the

735

language that I quoted and a payer would not?
A. Well, if a payer went to a report and read one line and read nothing more, then whoever is in charge of doing -- designing reimbursement rates should be fired, because that's -- you don't read one sentence. You need to know the full context of what is going on and what the implications are. You don't -- you don't -- the people that are doing this stuff and designing reimbursement rates do more than read one line in a report.
Q. Do you think a payer would read the conclusions to this report?
A. I think the payer would read the whole report.
Q. Well, take a look at the conclusions which appear on page 11.
(Witness complying.)
Q. The second bullet point is, quote, "AWP is not a reliable indicator of the cost of a drug to physicians," close quote.
Is it your testimony that a payer would

736

read that statement and conclude that AWP is larger than ASP by a reasonably predictable amount?
A. I would -- if -- if a payer came and read -- read the first sentence that you read, and then read the conclusion in that bullet, and read no more than that, then that's what -- then that's -- then that -- then that's grounds for incompetence in reimbursement design, and it -- I -- it's -- it would reflect that, you know, the people that are doing this kind of reimbursement design are nerds like me. They go to the data. And if one looks at the single-source drugs here, that is where they would look at. Oh, they would say, "Here is what they mean by not a reasonable guide. It is a few multi-source that are really not on our radar screen."
Q. Are you saying that OIG didn't know what it was talking about when it made that statement?
A. I am saying if I am characterizing this table as a whole and trying to generalize that, that for all of these drugs, speaking very

737

broadly, that when you include multi-source and branded physician-administered drugs in the same way as when you do that with self- administered drugs, there is -- there is -- there is wide variation between AWP and ASP.
But one would look at that then, and get -- would look -- would start at that point and then start to peel back the onion and look at the details and see where it was appropriate or not.
Q. So are you saying that you can't always rely on OIG's conclusions? You have to look at the details?
A. I am saying that anyone attempting to understand the results of a survey wants to look at -- you will -- someone who is doing a survey, you will look at the results and you will look at the details. You will look at -- you will look at all aspects of it that you can in order to be as informed as you can.
Q. Let's take a look at Appendix III to this report, and I want to direct your attention to the last sentence on the page where it states,

738

quote, "Considering that we also found that there is no single discount rate which can be applied to the AWP to provide a reasonably consistent estimate of physicians' acquisition cost, we do not feel that AWP provides a useful measure of the acquisition cost for a drug to physicians."

Is it your testimony that a payer reading that statement would nevertheless conclude that AWP is larger than ASP by a reasonably predictable amount?

A. It is again the drug you're pointing to is one of the multi-source drugs. It is methotrexate sodium. And we find that there is -- there is much greater variation in the multi-source drugs, and -- I've -- I've -- I haven't used those for that purpose. The data on characterizing a relationship between AWP and ASP for multi-source drugs is -- that kind of survey information is much more spotty, as has been recognized by Dr. Berndt and as I cite in my report, and so, you know, this is just summarizing the same thing.

739

Q. Isn't it a fact, Dr. Hartman, that a number of payers have testified to exactly what is stated in this OIG report, that they understood that there was no reasonably predictable relationship between AWP and ASP?

MR. SOBOL: Objection to the form.

A. Well, I know that --

MR. SOBOL: Objection to the form.

THE WITNESS: That was a double objection.

MR. SOBOL: Sorry.

A. There were a variety of depositions of payers that I reviewed, well, that were put forward by Mr. Young and Dr. Gaier that purported to demonstrate that payers didn't rely on AWP, that they had -- that they didn't give a damn about what the acquisition cost was, and there -- and stated a variety of things, and I have -- I have responded to -- to a large group of those in my rebuttal -- two rebuttal reports. I would have to see whether what you are going to put in front of me is one of those quotes.

740

But again, a quote from a deponent, I would have to see what the full context was, what that person knew, whether that person was really the person that was in charge of reviewing data and understanding what acquisition costs were and setting reimbursement rates. But given those caveats, I would be glad to read any depositions you want to put in front of me.

MR. EDWARDS: Well, let's mark as Exhibit Hartman 028 to this deposition a copy of the transcript of Mickie Brown.

THE WITNESS: Are we done with this one? Can I give this one back to you, the OIG?

MR. EDWARDS: You can put that one down.

(Deposition transcript of Mickie Brown taken March 9, 2005 marked Exhibit Hartman 028 for identification.)

BY MR. EDWARDS:

Q. I want to direct your attention to page 126 of the deposition.

A. Could you tell me who Mickie Brown is?

Q. I believe he was with Blue Cross/Blue

741

Shield of Mississippi.

A. And could you tell me what his job was there? Where does it describe what he is doing there?

Q. I don't have that information at my fingertips. I take it you're not aware of the answer to that either; is that correct?

A. Without -- I mean I may have looked at this in my rebuttal stage, but I don't remember precisely, so I am seeing Blue Cross of Mississippi on page 9, he left in '96.

Q. I take it you have never read this deposition; is that correct?

A. I don't recall whether I have or not.

Q. I believe on page 16 he testifies that he is the director of provider networks, but I want to direct your attention to the testimony that begins at line 20 on page 126. Do you have that?

A. Let me turn to that. Line? I am sorry. What page? I am sorry. I didn't hear the page.

Q. Page 126, line 20.

742

(Witness complying.)
A. Okay.
Q. "Question: Well, certainly we can agree that the AWP for any given drug bears no fixed relationship to acquisition cost for that drug; correct?
"Answer: As I have said before, I don't know where average wholesale price comes from, so the relationship of average wholesale price to acquisition cost is not something that I'm familiar with, so I don't know how I can agree or disagree with your statement.
"Question: Then it is certainly fair to say that you have no particular expectation that there will be a fixed relationship between AWP and acquisition cost?
"Answer: Average wholesale price is a point of reference that we use. Its relation to acquisition cost, I'm not familiar with, so I mean I don't have an expectation -- I don't have an expectation one way or the other on that."
How do you reconcile that testimony with

743

your opinion that payers have expected that AWP is larger than ASP by a reasonably predictable amount?
MR. SOBOL: Objection to the form.
A. My conclusion and those of the other persons cited in my report that there is a reasonable expectation characterizes the market as a whole. You are going to have market entities out there that are -- are unaware of a relationship and essentially are going to follow in terms of negotiating an acquisition cost -- I am sorry -- a reimbursement rate, they're going to follow some rule of thumb, percentage off AWP, and these are precisely -- these -- the -- those payers and those payers designing reimbursement rates for third-party payers that actually have no understanding of this relationship are at the mercy of, one, what the market expectation -- well, they are unaware of what the market expectations are, but these are precisely the payers that are most easily gouged by the alleged fraud, because they have no idea. They are just -

744

- they just -- they assume, well, AWP is what Medicare is using. 95 percent of AWP. I'm -- that seems to be what the government is doing. They must know what they are doing.
So there is going to be people with no expectations. It is like someone walking into a car dealer and seeing what the sticker price is and saying, "Well, okay, I will take it at that, I'm not going to negotiate it with you," doesn't look up on Carfacts, doesn't do any research. I read this as an uninformed payer that -- this doesn't mean that there is not a set of relationships that inform the market. This just means that there is one person that is not aware of it.
MR. EDWARDS: I will mark as Exhibit Hartman 029 a copy of the deposition transcript of Thomas E. Greenbaum taken on January 14, 2005.
(Deposition transcript of Thomas E. Greenbaum taken on January 14, 2005 marked Exhibit Hartman 029 for identification.)
A. You know, I would like to follow up with

745

just one further response on this previous exhibit.
You know, the -- it says that he is currently director of provider networks, but again we are pulling out -- you are pulling out one page of this fellow's deposition. I have no idea whether this is the person, you know, someone who is director of provider relationships, or provider networks, whether he is the person doing the negotiations. This doesn't really tell me what this entity, this payer, you know, unless I know this is the guy that is negotiating, you know, there is many a management person that is sitting there director of something and the details are left to somebody else.
So in addition to this person, whether he knew or not and whether he was being gouged or not, he may not be -- they may have a very good idea, this entity, of what the acquisition cost is. This person doesn't (pointing to Exhibit Hartman 028). He may not be the person who is going to know anything about that.

746

Q. Do you know how Mr. Brown was chosen as a witness?
A. My guess would be that he was designated in response to a 30(b)6 that said, "We would like to speak to somebody who knows about reimbursement rates."
Q. It says, "Please produce the person most knowledgeable about this subject."
A. Um-hmm.
Q. Is that consistent with your understanding?
A. I have not --
MR. SOBOL: Objection to the form of the question.
THE WITNESS: Yes.
A. I have not seen -- I have -- I have been on the requesting end of many 30(b)(6)s where I have asked for a person in that context and gotten someone who didn't know what it was, but I -- I would assume you have asked for somebody who did know.
I don't know whether this person -- I

747

don't -- I would have to read this fully to establish his bona fides to establish whether he really does know.
Q. Blue Cross/Blue Shield of Mississippi is a class member in this case; correct?
A. I would assume so.
Q. These are the people that Mr. Sobol represents; correct?
A. The -- Mr. Sobol represents the third-party payers and the beneficiaries, the class as it is defined.
Q. They are the people who are alleging that these defendants should be held liable and should be required to pay money; correct?
A. They are -- they are one of the -- one of the subclasses. They are subclass 2 and part of subclass 3. They are not in subclass 1.
Q. So it is certainly not in their interest to bend over backwards to help the defendants here; correct?
MR. SOBOL: Objection to the form.
A. I'm -- it is certainly reasonable to

748

believe that whomever they would produce it would be somebody who would help in this particular -- help in understanding an area where they are a stakeholder. I don't know whether they have or not. I -- that --
Q. I want you to take a look at the transcript of the deposition of Thomas Greenbaum, which we have marked as Exhibit Hartman 029.
(Handing Exhibit Hartman 029 to the witness.)
Q. He is from Cigna. Cigna is a large, sophisticated payer; is that correct?
A. They are a -- they are a large payer. That's true.
Q. I want to direct your attention to the testimony that begins at line 12 on page 75.
A. You know, before I get directed to any testimony, I just want to see who this person is besides his name.
(Pause.)
(The witness viewing Exhibit Hartman 029.)

749

Q. Take a look at page 6, line 9. "I'm the chief operating officer of CIGNA pharmacy."
A. Okay. I just want to look at kind of his background a bit here.
(Pause.)
(The witness viewing Exhibit Hartman 029.)
A. So this is -- I mean I am looking at a little bit more of his background, and it -- it sounds like Brownie of FEMA. I mean I go to the bottom of page 8, and it says -- or I am sorry -- of 6 and 7 -- "Can you tell me in broad terms prior to coming to Cigna three years ago about your employment background?"
"I worked as a general manager of the Book of the Month Club. Prior to that I was chief operating officer of Marvel Entertainment and prior to that I worked for an entertainment products company in Wisconsin."
So it would be correct to say that prior to coming to Cigna three years ago you had not previously worked in the healthcare insurance

750

industry; is that true?
Okay. So conditioning that on that person's understanding of this industry, what is it that you want me to look at?
Q. Well, when you compare this person to Brownie of FEMA, what did you have in mind? Are you trying to infer that this person is somehow incompetent?
A. No. I am saying that as with, I think, Mr. Brown's bona fides were that he had been head of the Arabian Horse Society prior to being placed as head of FEMA, and that that experience did not give him a nuanced deep understanding of what was necessary for the job into which he was placed, and I -- so I look at this, and I see that someone does not have a -- I mean he is the COO of Cigna, but I'm not seeing a long history of understanding the nuances of all that is -- Cigna is a big company, and it is doing -- it is doing reimbursement for physicians and for hospitals, it is doing all kinds of information management, and along with prescription reimbursement and

751

reimbursement for physician- administered drugs, and I just wanted to see what -- this is a background that doesn't argue a nuanced deep understanding to me, but, and I just wanted to get that in the record. I just wanted to know what his background was.
Q. Well, is it your testimony that to the extent that any payer claims it was injured here it is because they were not competent, like Brownie here?
A. No. It is my testimony that there -- there were -- there were expectations in the market, and there were -- that -- that essentially those expectations that developed in the late '80s, early '90s, relative to these particular drugs, physician-administered drugs, and the relationship of AWP to acquisition costs of the providers was set in Medicare's mind and in third-party payers' minds in the early '90s, and they changed very slowly, and people weren't aware, weren't aware of all of that.
And so the -- it is -- it is very easy

752

for even knowledgeable third- party payers that haven't -- are not paying attention to this one particular aspect of things, where this is an area that can be abused easily by manufacturers, as we see in the Vincasar matter that I cited earlier in my report in the paragraph that quotes Medpac or that were exploited in the Lupron matter. These were -- these were drugs and these were reimbursement rates that were low on the radar screen in Professor Berndt's nomenclature, and so someone that is relatively well informed would not notice the abuse of this spread, and certainly someone who has little background in it is easily duped or could be -- the alleged fraud would be particularly easy to impose upon someone -- a payer like this if this is the person negotiating reimbursement rates.
Q. So it is your testimony that Cigna was duped?
A. It is my testimony as I read -- you have put a deposition in front of me. I am looking at the background of the person, because you are

753

asking me a question about what he knew, and I am looking at his background, and I see that his background suggests to me that he hasn't spent a lot of time studying this market to know that much, and that's all I am saying.
And so --
Q. Take a look at page 75 beginning at line 12.
(Witness complying.)
Q. And this is part of a question:
"Would the same statement that you just made hold true for the actual acquisition cost, that Cigna does not have an expectation of a relationship between average wholesale price or actual acquisition cost but in fact those are two separate pieces?"
And then there are a series of objections.
"Answer: Yeah. I mean I think that our acquisition costs are separate from AWP, and we don't have any expectations of what the relationship is between what we purchase the drug

754

for and what AWP is."
Now given that testimony, do you think that your opinion that payers have expected that AWP is larger than ASP by a reasonably predictable amount simply doesn't apply to Cigna?
MR. SOBOL: Objection to the form.
A. I'm saying -- I am saying that the expectations that I have framed and analyzed and put forward in my report summarize the market as a whole for those -- for those groups who have been surveyed, for those payers for which contracts have been negotiated, and there are going to be -- I would like to see Cigna's contracts with -- with -- with an oncology group to see what was actually negotiated.
The -- you know, I am seeing -- I am sorry. I was trying to see whose all of these names here were.
This is a person who I would assume when negotiating contracts -- this is a senior person that is not close to those details given his background and given the response.

755

So this -- this is again -- has no evidentiary value that I see really even about what Cigna was doing or what Cigna knew.
Q. So are you saying that when you summarize expectations in the marketplace you ignore all evidence that is contrary to your hypothesis?
MR. SOBOL: Objection to the form.
A. No. I seek evidence wherever I can get evidence of someone knowledgeable about what it is I'm analyzing, and from what I see here, this deponent has little credibility as to an understanding of what expectations were, relations were, period.
Q. I want to show you the deposition of Jill Herbold taken January 14, 2005, which I will mark as Exhibit Hartman 030.
(Deposition transcript of Jill A. Herbold taken on January 14, 2005 marked Exhibit Hartman 030 for identification.)
MR. EDWARDS: And I apologize to anybody who might listen to the audio of this deposition

756

for constantly coughing on the record. I just can't help it.
THE WITNESS: Can I offer you a Halls?
MR. EDWARDS: Maybe at the break.
BY MR. EDWARDS:
Q. You said --
A. Could I just take a second, if you would bear with me?
(Pause.)
(The witness viewing prior exhibit.)
A. I just want to review one of the prior exhibits that you had put before me.
(Further pause.)
(The witness continues to view prior exhibits.)
A. Okay. I am sorry.
Q. Now you testified a moment ago when I was asking you questions about Mr. Greenbaum that you would like to see Cigna's contracts in order to evaluate his testimony about the relationship between AWP and ASP; correct?

757

A. And I -- I think you have been very good in finding me a person who might help in that regard.
I did say that. Yes.
Q. I take it you have never asked plaintiffs' counsel to provide you with copies of Cigna's contracts, have you?
A. I have asked for contracts, and I forget what was provided. It is my recollection that we did not receive -- I did not receive a lot of contracts. I certainly relied on some contracts that were put forward by Mr. Young, but I did ask for contracts. I didn't -- I don't think I received any, but I would have to look. I can't recall.
Q. Well, you identify contracts for physician-administered drugs that you rely on in attachment C --
A. I do, yes.
Q. -- to your declaration; correct?
A. That's correct.
Q. And basically you identified four

758

contracts; correct?
A. And I think those four contracts were ones that I was able to get from defendants.
Q. None of those are Cigna contracts; correct?
A. I would assume not, but I -- I am trying to think whether --
(Pause.)
(The witness viewing Exhibit Hartman 023.)
A. -- in my rebuttal reports I had seen Cigna contracts, but that is something I can check.
Q. Okay. Let's go back to Ms. Herbold's deposition. She is also with Cigna; correct?
A. Yes. It appears that as far as I can tell she is responsible for strategy and policy as well as financial analysis for practitioner reimbursement, and so she is an assistant VP practitioner reimbursements. She has been that since 2004, so she has been doing that job since fairly recently, and --

759

Q. I want to direct your attention to page 21 of this deposition beginning at line 8.
(Witness complying.)
Q. "Question: Can you tell me the range below AWP that these rates and the Cigna national standard injectable reimbursement rate was varied?
"Answer: Typically 15 percent. We have codes that are up to 45 percent below AWP."
Do you see that?
A. I do.
Q. So Cigna's contracts do not fall within the plus or minus 15 percent of AWP range on which you premise your report; correct?
MR. SOBOL: Objection to form.
A. Well, certainly their typical contract does. Now they claim they have codes up to 45 percent below AWP, and I would assume that is for a multi-source, and I would have to -- I would have to -- as to typicality, I see 15 percent. As to whether -- how much of an exception 45 percent is, and this is again as of 2004, and there certainly have been more multi-source drugs

760

recently, in the last five years of the physician administered, so I would assume that that applies to multi-source.
Q. So that would be another example of payer expectation with respect to multi-source differing from the expectation with respect to single source?
A. This is one piece of evidence regarding as of 2004 what a relationship would be for a multi-source product.
Q. Next I want to show you the transcript of the deposition of Joe Spahn taken November 30, 2004.
MR. EDWARDS: This will be Exhibit Hartman 031.
(Deposition transcript of Joe Spahn taken on November 30, 2004 marked Exhibit Hartman 031 for identification.)
(Handing Exhibit Hartman 031 to the witness.)
BY MR. EDWARDS:
Q. Mr. Spahn is with Anthem. Do you know

761

what Anthem is?
A. It is my recollection that Anthem is a Blue Cross/Blue Shield, but I would have to confirm that. Oh, yes. There it is. Anthem Blue Cross/Blue Shield.
Q. Anthem is an amalgamation of a number of Blue Cross/Blue Shield entities; correct?
A. That -- it's -- I think that's correct. I don't know how many, and I would have to confirm that.
Q. Do you know whether Anthem is at this point the largest payer in the country?
A. As of today, you mean?
Q. Yes.
A. I don't know.
Q. What I want to do is direct your attention to the testimony that begins at page 93, line 6.
"Question: Now you testified earlier that Anthem has -- does not know exactly what providers are paying to acquire drugs; correct?
"Answer: Correct.

762

"Question: That is not something that -- withdraw that.
"Anthem does not require providers to disclose their acquisition cost for drugs as part of their contracts with those providers; correct?
"Answer: Correct.
"Question: So providers' acquisition costs for drugs do not form part of Anthem's determination of what it will reimburse them in relation to drugs?
"Answer: Correct.
"Question: The reimbursement is driven entirely by the fee schedule?
"Answer: Correct.
"Question: Regardless of what the specific providers' acquisition cost for those drugs may be?
"Answer: Correct.
"So if, for example, Anthem were to learn that a particular provider were getting a discount or a rebate on a particular drug that lowered his acquisition cost for that drug, that

763

wouldn't change the amount that Anthem is reimbursing that practice in relation to that drug; right?
"Answer: No.
"Because the reimbursement amount is tied to the fee schedule?
"Answer: Right.
"Question: And if Anthem were to learn that providers in a region were getting a discount or rebate from a drug manufacturer in relation to a particular drug, again that wouldn't change the amount that Anthem reimburses because that is tied to the fee schedule?
"Answer: That's correct.
And then continuing on page 97, beginning with line 17, "Prior" -- question:
"Prior to the break, we were talking about providers' acquisition cost and the fact that they are not relevant to Anthem's reimbursement amounts. Do you recall that testimony?
"Answer: Yes.

764

"Question: Okay. And part of that was that Anthem has no information about the providers' acquisition costs? Right?
"Answer: Correct.
"Question: So it is fair to say that Anthem has no particular expectation that providers' costs would be, you know, 10 percent, 30 percent, 50 percent, something more, something less than the amount they're reimbursed in relation to those drugs? Right?
"Answer: Yes."
Now based on that testimony, would it be fair to say that your opinion that payers have expected that AWP is larger than ASP by a reasonably predictable amount would not apply to Anthem?
A. What this says to me is what occurred over the '90s and into the early 2000s, and that is that there were a set of expectations going into that period of time of what the relationship was, and that formed expectations as cited by Mr. Young as laid out in the 1992 OIG report for

765

single-source drugs, as reflected in contracts that were negotiated over this entire period of time, and what was also the discussions that were going on Congressionally about Medicare. That there were expectations in place that governed reimbursement of both Medicare and third-party payers looked to Medicare and discounts off of AWP and how they reimbursed. There was a growing awareness with both the legal action and once managed healthcare dealt with some of the larger cost issues, like hospitalization and physician costs, they started focusing on issues about prescription drugs and then physician-administered drugs.
And this says to me that Anthem, going into this, that they didn't -- they don't have the information they need to know more than relying on the general kinds of rules of thumb that have characterized this market and that has been able to be abused by the manufacturers, and so they have locked into a computer system and a reimbursement system a set of AWPs and

766

reimbursements off of AWPs, and I know there are private third-party payers that are starting to evaluate this kind of issue now and starting to learn that there is a bigger gap than they thought, but this is something that is only recent, and it hasn't been -- this is precisely why this has been a lucrative area to exploit by the kind of behavior that is alleged on the part of manufacturers.

Q. If you look at pages 8 and 9 of this deposition, you will see that Mr. Spahn testifies that he has served as senior healthcare consultant to Anthem since 1992. Do you see that?

A. I do.

Q. And he doesn't say in the testimony that we just read that his views of this matter have changed over the period of time since 1992 to the present, does he?

A. He -- you are asking -- there is -- there is -- there is hundreds -- there is 174 pages of deposition here, and for -- I'm not going to attempt to characterize that particular set of

767

quotes.

What page was that again? Oh, here we go.

Q. The quotes we read were from --

A. No. I see it. I have got it.

Q. -- I think 93 to 97.

A. The quotes?

Q. Or 98. Pages 93 to 98.

A. Okay. I thought -- yes. Not years.

Yes. I mean I am -- I am -- I would assume that as of now, 2004-2005- 2006, that these -- that providers are beginning to realize that these expectations, the expectations that they have relied on to write their contracts, that is reflected in all of the testimony that I have cited and the surveys that I have cited and what the Judge has relied on, reflected a period of time where the spreads have obviously been exploited in very dramatic fashion, as recognized by Dr. Berndt, and payers are beginning to say, you know, there is something -- we need to be thinking about acquisition costs. I don't know

768

what it is right now, and because our systems of reimbursement are hard wired to AWP, I don't know what it is. We can't work with that. But I know that third-party payers are beginning to try to, precisely because they -- the extent of the problems alleged in this matter are becoming clear.

Q. What is the basis for your testimony that Mr. Spahn's expectations have changed since 1992?

MR. SOBOL: Objection to the form.

A. I didn't say Mr. Spahn's. I am saying that the -- as a -- as a matter of information, that is -- that is compelling, we have talked about this 1992 OIG report that the -- how much that was disseminated as to the multi-source spreads is unclear -- is unclear to me, but what is clear and has become clear, as I have said in paragraph 53A, and these are events where we have had the Lupron behavior becoming known, that was behavior going on in the '90s, and exploiting understandings of reimbursement in the '90s, and

769

it became clear in 2000 -- with the litigation, and then with the settlement agreement with 2001, the sentencing memorandum, there were hearings before the House Energy Subcommittee, and if you will give me leeway to find one more.

(Pause.)

(The witness viewing Exhibit Hartman 023.)

Q. Would you agree with me that --

A. I would like to get just this one last statement in the record, if I could.

(Further pause.)

(The witness continues to view Exhibit Hartman 023.)

A. And there is probably a time limit at some point.

MR. EDWARDS: While you are looking, why don't I have the reporter mark the next deposition exhibit, which is Exhibit Hartman 032.

(Deposition transcript of Edward Lemke taken on January 11, 2005 marked Exhibit Hartman 032 for identification.)

770

THE WITNESS: Yes. I can't find it.
MR. EDWARDS: It is the deposition of Edward Lemke, taken on January 11, 2005.
THE WITNESS: Oh, wait. I found it. It is also the quote put forward by Dr. Berndt at page 42 of his report where again he is stating fairly recent understandings, and he says, this is in footnote 12, he says, "In a different industry publication, an executive of Advanced PCS reports that in his experience health plans become flabbergasted on what they are paying for years on drugs on the medical side because of dramatic price markups."
So this is again another summary of a recent understanding of what has occurred over the period of the '90s.
Q. Take a look at the deposition of Edward Lemke of Humana, which we have marked as Exhibit Hartman 032.
(Handing Exhibit Hartman 032 to the witness.)
Q. Have you read this deposition before?

771

A. I think I -- I think I have seen parts of it. I think in terms of reviewing defendants' experts, I had read part of this, but I can't recall.
Q. I just want to direct your attention --
A. I am sorry. I just want to find out who this person is before we --
Q. You may want to look at page 18, where Mr. Lemke states that he is director of fee schedule management for Humana.
(Witness complying.)
A. Okay. Humana. Okay.
Q. Let me ask you to look at page 123, beginning at line 17.
(Witness complying.)
Q. "Question: Is it Humana's expectation that the amounts that providers pay to acquire drugs are a fixed percentage less than the amount Humana reimburses in relation to those drugs?
"Answer: The expectation that first of all that it's fixed, no. The expectation that good business practice, and assuming providers

772

that we do business with practice good business practices, is that they would only accept payment that is at or above their costs."
A. I --
Q. "That is my only expectation --"
A. Counsel, I am sorry. I missed the -- I thought I had the page, and I have been looking for the words. Could you tell me?
Q. Sure.
A. Just start me.
Q. It starts at 123.
A. Page 123, okay.
Q. Line 17.
A. Okay. I am sorry.
Q. And what I just read you is line 17 on page 123 through line 4 on page 124.
A. Okay.
(Pause.)
(The witness viewing Exhibit Hartman 032.)
Q. Where he says it is his only expectation that they would want payment at or above their

773

costs.
And then continuing on:
"Question: And certainly you have no fixed expectation as to how much higher it would be than their acquisition cost; correct?
"Answer: Correct.
"Question: And indeed that would vary from provider to provider depending on what they paid to acquire drugs and what Humana reimburses them for drugs?
"Answer: Correct.
"Question: The percentage could be 10 percent in one case, 50 in another, 100 in another; correct?
"Answer: Could be."
Now, Dr. Hartman, is it fair to say that your conclusion that payers have expected that AWP is larger than ASP by a reasonably predictable amount does not apply to Humana?
A. No.
Q. Well, if the Court or the jury finds that the testimony of Mr. Brown, Mr. Greenbaum,

774

Mr. Spahn, and Mr. Lemke is more representative of market expectations than the sources you have cited for market expectations, what does that do to your report?

MR. SOBOL: Objection to the form.

A. Well, right now there has been quotes from people about -- about very general kinds of statements, you know, that -- that tell me that this person doesn't really know and is relying on the general rules of thumb that have characterized this market for physician- administered drugs. The fact that it is 10 percent, 50 or 100, he said, "Could be," I would want to see the contracts. I would want to see, before I would introduce this into evidence, here I have got -- I have got contractual information; I have got survey information on what people pay.

He is talking about again there, just like what we were saying before, there could be a variety of thoughts about what could be the case of what I'm going to pay. When you step up to the, belly up to the bar and you sign a contract,

775

then you see what it is for the different kinds of drugs.

And so I see 10 percent. I don't know. 50 percent, 100 percent. In a multi-source context? This is again in 2005 when the information was much different than the preponderance of the class period. 2005 is not even in my damage calculations.

Q. Would you --

A. So -- so I want to see contracts. I would want to see the contracts of these companies.

Q. Would you agree with me that Mr. Lemke at least did not believe that AWP is larger than ASP by a reasonably predictable amount?

MR. SOBOL: Objection to the form.

A. I don't think the question is -- I -- I can't judge from this, this set of responses and this set of questions. It is too general and too diffuse. It is -- it --

Q. Where he agrees that the percentage could be 10 percent in one case, 50 in another,

776

100 in another, is it your testimony that that is consistent with your opinion that payers believe that AWP is larger than ASP by a reasonably predictable amount?

A. My opinion goes to single-source physician-administered drugs, as I have said, in basing it on the information that I have looked at, I extended to multi- source later, and discuss how I -- how that -- what my assumptions are therein.

But this is so broad and diffuse, this, this doesn't tell me -- I don't know what he is talking about. I don't know if it is single source. I don't know if it is multi-source, if it is a particular type of drug. I don't know if it's -- I don't know what -- it is too -- it is too -- too broad, too general.

Q. Your opinion that payers have expected that AWP is larger than ASP by a reasonably predictable amount is what an economist would call a hypothesis; correct?

MR. SOBOL: Objection.

777

A. It is -- it -- it could be called a hypothesis. It could also be called a conclusion. And I've -- I approached this with a hypothesis and came to a conclusion that it is the case.

Q. Okay. And the thing that gets you from a hypothesis to a conclusion is an examination of the evidence; correct?

A. That's right.

Q. And yet you are rejecting the evidence that I have put forward to you from the depositions of Mr. Brown, Mr. Greenbaum, Mr. Lemke, and Mr. Spahn, and you are adhering to your conclusions; correct?

A. No. I am -- the -- this is not evidence as to what the actual -- what the reimbursement rate, what the -- the contractual discounts off of AWP would reflect whatever this understanding would be, that -- that -- that's -- those are when you survey it and you look at the actual numbers, as I have cited in here, you look at what the contracts say, there is going to be very -- it is like flying, getting on an airline. There are --

778

there are list prices, and there are lots of different discounts, and you are going to negotiate, and you are going to -- and there is going to be a list price that is going to reflect certain things, and you may -- you may have -- it could be anything.

But what is going to finally count is what you pay, what you set that rate at. And so I don't know what this says about -- I want to see the contracts of this, for this payer, to know what -- how the very vague understandings that are articulated here are reflected in a real decision that is made contractually or in real data. I mean this is -- you are -- this is very ill-formed hearsay.

Q. So you are saying that --

MR. SOBOL: Wait, wait, wait.

Q. -- the evidence --

MR. SOBOL: It is one o'clock. Let's take lunch.

MR. EDWARDS: Could I ask just two more questions on this line?

779

MR. SOBOL: Actually, no, because I have a call.

MR. EDWARDS: Please?

MR. SOBOL: No. Not even if you say "pretty please."

THE VIDEOGRAPHER: The time is 1:02. We are off the record.

(Luncheon recess taken at 1:02 p.m.)

780

AFTERNOON SESSION 1:47 P.M.

THE VIDEOGRAPHER: The time is 1:47. We're back on the record.

CONTINUED DIRECT EXAMINATION OF DR. HARTMAN BY MR. EDWARDS:

Q. Dr. Hartman, a while ago we were talking about the possibility of conducting surveys that you had mentioned in your prior deposition, and I believe you testified that you decided not to conduct those surveys in part because you had deposition evidence available; is that correct?

A. That was one of the reasons, yes.

Q. What were the other reasons?

A. Well, the other reason was really to get at the issues involved would require just implementing and designing an appropriate survey would take time and would be involved to do properly and do scientifically, and also to try and do a survey going back where you are just trying to get at expectations rather than revealed

781

behavior, going back that far is very hypothetical and very speculative. So it -- it was more useful to look at the information that I looked at and look at the depositions that I looked at.

Q. Did you discuss the possibility of conducting surveys with counsel for the plaintiffs?

A. You know, I think I raised it as a possibility early on, as I was clear in the declaration. The decision not to do it came from me, not from them. So, yes, there was some discussion, but.

Q. What was their position on that?

A. I don't recall.

Q. And just so the record is clear, it is your testimony that the testimony of payers that we have reviewed thus far, the Brown deposition, the Greenbaum deposition, the Lemke deposition, the Spahn deposition, does not have an impact on the conclusions you have expressed in your report?

A. Those -- those opinions as they are expressed and as they are discussed and as they

726

Physicians' Costs for Chemotherapy Drugs, November 1992 marked Exhibit Hartman 027 for identification.)
BY MR. EDWARDS:
Q. Dr. Hartman, I have asked the court reporter to mark as Exhibit Hartman 027 a copy of the OIG report on Physicians' Costs for Chemotherapy Drugs dated November 1992.
(Handing Exhibit Hartman 027 to the witness.)
Q. Do you have that report in front of you?
A. I do.
Q. And is this the report that you cite in your declaration?
A. I think that it is.
(Pause.)
(The witness viewing Exhibit Hartman 027.)
A. I am quite sure that it is.
Q. I think you identify it in paragraph 22B on page 16?
A. Right. Yes. I think I -- I do. I

727

don't cite it there, but I have cited it before, so I think this is the same one. I mean I cite it, but I don't have the full citation. I know there is always a number of these studies that they put out, but this looks like the one.
Q. And it is your testimony that this report helped to inform market expectations as to the relationship between ASP and AWP?
A. It summarized what -- what those -- what spreads were and helped inform that relationship, yes.
Q. And it helped inform the market expectation that AWP is larger than ASP by a reasonably predictable amount?
A. For single-source physician-administered drugs, it does -- it did, yes, as I say in that paragraph.
Q. Okay. Why don't you take a look at page 2 of Exhibit Hartman 027. I want to direct your attention to the statement that appears at the top of the page, quote, "Our results indicate that for the physicians surveyed the 13 chemotherapy drugs

728

can be purchased at amounts below AWP and that AWP is not a reliable indicator of the cost of a drug to physicians."
Do you see that?
A. I do.
Q. Does that have any impact on your opinion that the marketplace expected that AWP is larger than ASP by a reasonably predictable amount?
A. By "mine," I take it you mean mine and everyone else that I have cited as comporting with my understanding.
What -- what is being summarized here, it seems to me, is unfocused in that I think the -- one needs to go to the actual data where the amounts are cited, and that is provided in Appendix III, where it lists the invoice costs relative as a percentage of AWP, the invoice cost for branded manufacturers and to oncology wholesalers, and for single-source drugs, what you see there is either under the branded manufacturer, the oncology wholesalers, there is

729

for the single- source drugs, and that was what I'm referring to in that particular paragraph, a fairly -- a fairly tight relationship between AWP and the invoices of the branded manufacturers of the oncology wholesalers that ranges anywhere from 12, what I am seeing here, 12 to 20 percent.
Now there certainly are a few multi-source drugs listed here where the AWP is -- varies more than that, and I'm assuming that is probably what they're referring to, and what -- what I'm -- what I have said here is that I'm looking at single-source drugs, and single-source drugs were at the beginning of the 1990s, the beginning of this damage period, certainly those were the ones that were the most prevalent and what -- what was informing people's opinions about drug relationships, and I think with the drugs in the class in my table 2, I think almost all of them were single source in 1990, 1991, and 1992 when this was done. They became -- several of them became multi-source over the period.
But as Dr. Berndt has said, that the

730

information on the relationship of AWP and ASP for multi-source physician- administered drugs is -- there has been little that really has helped make that very clear, and here is some -- some information, but it's -- it is mostly aimed at some generic drugs, and even some of the generic drugs fall within the -- within the 11 to 20 percent. There is interferon is at 9 to 14 percent on the oncology.

So there are -- there are several multi-source drugs where that relationship deviates from what I am talking about here, but I have focused this on single-source drugs, since that has been the focus of much of the damage period in many of the drugs.

Q. Is it your testimony that a payer reading this report would conclude that multi-source drugs are different from single- source drugs and there is not a predictable relationship between AWP and ASP with respect to multi-source drugs?

A. It's -- it's my opinion that as to

731

physician-administered drugs, private sector third-party payers for the most part look to Medicare and how Medicare was developing its relationships, and the Medpac report confirms that reliance.

So there -- there is some limited information, but in -- as in any kind of market, there is -- pieces of information start to come to light, but they don't -- they don't start to affect expectations for a while. These markets are slow to respond to this, and you see the same thing with the OIG studies of the relationship -- the spreads on self- administered drugs, generics and branded, and they -- they weren't recognizing until later in the '90s that the generic spreads were that large.

So in answer to your question, there is some information here, but it is, as far as I can see from the contracts and everything else, this did not affect what -- how Medicare was ending up setting its reimbursement rates nor how third-party payers were. This was the beginning of an

732

understanding that finally culminated in say 2004 with the Medicare -- with the Prescription Drug Modernization Act.

Q. Well, are you saying that the marketplace had a different expectation for multi-source drugs than it had for single-source drugs?

A. We're talking about physician-administered drugs now; is that right?

Q. Yes.

A. I'm saying that for the -- for the focus of third-party payers negotiating reimbursement rates for different, whether it is for self-administered drugs, whether they are working with their PBMs, whether they are working with providers for physician-administered drugs, that physician-administered drugs was one of the categories of costs that was the smallest speck on the radar screen, and they paid little attention to it, and this is -- this is corroborated or that -- this opinion is certainly put forward by Dr. Berndt, that drugs generally were not on the radar screen. Physician- administered drugs were a much

733

smaller part. And multi-source were even a smaller part of physician-administered drugs going into the 1990s.

So this kind of information, it was starting to pop up, but this was not shaping general expectations as I see in contracts and in revealed preferences from the sources that I have cited.

Q. I believe you testified that it is your testimony that this report is one of the things that informed the market expectations that you found in your analysis; correct?

A. For single-source physician-administered drugs.

Q. So your testimony that a payer reading the language, quote, "AWP is not a reliable indicator of the cost of a drug to physicians," close quote, would conclude that AWP is larger than ASP by a reasonably predictable amount?

A. It is my conclusion that anyone who was a -- that the only person that would read this report and read that one sentence would be --

730

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A. It is my conclusion that anyone who was a -- that the only person that would read this report and read that one sentence would be --

734

would be a lawyer trying to make a point.
This -- someone reading this report would take -- and someone who is focusing on what payers are thinking about, what is going on -- is going to read the whole report, and if it is 1992 and I'm looking at this and I look at all the drugs in our class -- and I am willing to bet that almost all of them were single source in 1991-'92 -- I have got it in a footnote, we can check that, but certainly almost all of them were -- someone looking at this would say ah-ha, you know, in the early '90s physician-administered drugs, a lot of them had not gone generic yet. They were single source. A few did.
What am I looking at here? I am reading the whole thing. I am looking at single- source drugs. Well, this characterizes most of what I'm getting in my claims, and I am looking at what relationships are, and I'm -- that's what I'm seeing.
Q. Do you have any factual basis for concluding that only a lawyer would read the

735

language that I quoted and a payer would not?
A. Well, if a payer went to a report and read one line and read nothing more, then whoever is in charge of doing -- designing reimbursement rates should be fired, because that's -- you don't read one sentence. You need to know the full context of what is going on and what the implications are. You don't -- you don't -- the people that are doing this stuff and designing reimbursement rates do more than read one line in a report.
Q. Do you think a payer would read the conclusions to this report?
A. I think the payer would read the whole report.
Q. Well, take a look at the conclusions which appear on page 11.
(Witness complying.)
Q. The second bullet point is, quote, "AWP is not a reliable indicator of the cost of a drug to physicians," close quote.
Is it your testimony that a payer would

736

read that statement and conclude that AWP is larger than ASP by a reasonably predictable amount?
A. I would -- if -- if a payer came and read -- read the first sentence that you read, and then read the conclusion in that bullet, and read no more than that, then that's what -- then that's -- then that -- then that's grounds for incompetence in reimbursement design, and it -- I -- it's -- it would reflect that, you know, the people that are doing this kind of reimbursement design are nerds like me. They go to the data. And if one looks at the single-source drugs here, that is where they would look at. Oh, they would say, "Here is what they mean by not a reasonable guide. It is a few multi-source that are really not on our radar screen."
Q. Are you saying that OIG didn't know what it was talking about when it made that statement?
A. I am saying if I am characterizing this table as a whole and trying to generalize that, that for all of these drugs, speaking very

737

broadly, that when you include multi-source and branded physician-administered drugs in the same way as when you do that with self- administered drugs, there is -- there is -- there is wide variation between AWP and ASP.
But one would look at that then, and get -- would look -- would start at that point and then start to peel back the onion and look at the details and see where it was appropriate or not.
Q. So are you saying that you can't always rely on OIG's conclusions? You have to look at the details?
A. I am saying that anyone attempting to understand the results of a survey wants to look at -- you will -- someone who is doing a survey, you will look at the results and you will look at the details. You will look at -- you will look at all aspects of it that you can in order to be as informed as you can.
Q. Let's take a look at Appendix III to this report, and I want to direct your attention to the last sentence on the page where it states,

738

quote, "Considering that we also found that there is no single discount rate which can be applied to the AWP to provide a reasonably consistent estimate of physicians' acquisition cost, we do not feel that AWP provides a useful measure of the acquisition cost for a drug to physicians."

Is it your testimony that a payer reading that statement would nevertheless conclude that AWP is larger than ASP by a reasonably predictable amount?

A. It is again the drug you're pointing to is one of the multi-source drugs. It is methotrexate sodium. And we find that there is -- there is much greater variation in the multi-source drugs, and -- I've -- I've -- I haven't used those for that purpose. The data on characterizing a relationship between AWP and ASP for multi-source drugs is -- that kind of survey information is much more spotty, as has been recognized by Dr. Berndt and as I cite in my report, and so, you know, this is just summarizing the same thing.

739

Q. Isn't it a fact, Dr. Hartman, that a number of payers have testified to exactly what is stated in this OIG report, that they understood that there was no reasonably predictable relationship between AWP and ASP?

MR. SOBOL: Objection to the form.

A. Well, I know that --

MR. SOBOL: Objection to the form.

THE WITNESS: That was a double objection.

MR. SOBOL: Sorry.

A. There were a variety of depositions of payers that I reviewed, well, that were put forward by Mr. Young and Dr. Gaier that purported to demonstrate that payers didn't rely on AWP, that they had -- that they didn't give a damn about what the acquisition cost was, and there -- and stated a variety of things, and I have -- I have responded to -- to a large group of those in my rebuttal -- two rebuttal reports. I would have to see whether what you are going to put in front of me is one of those quotes.

740

But again, a quote from a deponent, I would have to see what the full context was, what that person knew, whether that person was really the person that was in charge of reviewing data and understanding what acquisition costs were and setting reimbursement rates. But given those caveats, I would be glad to read any depositions you want to put in front of me.

MR. EDWARDS: Well, let's mark as Exhibit Hartman 028 to this deposition a copy of the transcript of Mickie Brown.

THE WITNESS: Are we done with this one? Can I give this one back to you, the OIG?

MR. EDWARDS: You can put that one down.

(Deposition transcript of Mickie Brown taken March 9, 2005 marked Exhibit Hartman 028 for identification.)

BY MR. EDWARDS:

Q. I want to direct your attention to page 126 of the deposition.

A. Could you tell me who Mickie Brown is?

Q. I believe he was with Blue Cross/Blue

741

Shield of Mississippi.

A. And could you tell me what his job was there? Where does it describe what he is doing there?

Q. I don't have that information at my fingertips. I take it you're not aware of the answer to that either; is that correct?

A. Without -- I mean I may have looked at this in my rebuttal stage, but I don't remember precisely, so I am seeing Blue Cross of Mississippi on page 9, he left in '96.

Q. I take it you have never read this deposition; is that correct?

A. I don't recall whether I have or not.

Q. I believe on page 16 he testifies that he is the director of provider networks, but I want to direct your attention to the testimony that begins at line 20 on page 126. Do you have that?

A. Let me turn to that. Line? I am sorry. What page? I am sorry. I didn't hear the page.

Q. Page 126, line 20.

742

(Witness complying.)
A. Okay.
Q. "Question: Well, certainly we can agree that the AWP for any given drug bears no fixed relationship to acquisition cost for that drug; correct?
"Answer: As I have said before, I don't know where average wholesale price comes from, so the relationship of average wholesale price to acquisition cost is not something that I'm familiar with, so I don't know how I can agree or disagree with your statement.
"Question: Then it is certainly fair to say that you have no particular expectation that there will be a fixed relationship between AWP and acquisition cost?
"Answer: Average wholesale price is a point of reference that we use. Its relation to acquisition cost, I'm not familiar with, so I mean I don't have an expectation -- I don't have an expectation one way or the other on that."
How do you reconcile that testimony with

743

your opinion that payers have expected that AWP is larger than ASP by a reasonably predictable amount?
MR. SOBOL: Objection to the form.
A. My conclusion and those of the other persons cited in my report that there is a reasonable expectation characterizes the market as a whole. You are going to have market entities out there that are -- are unaware of a relationship and essentially are going to follow in terms of negotiating an acquisition cost -- I am sorry -- a reimbursement rate, they're going to follow some rule of thumb, percentage off AWP, and these are precisely -- these -- the -- those payers and those payers designing reimbursement rates for third-party payers that actually have no understanding of this relationship are at the mercy of, one, what the market expectation -- well, they are unaware of what the market expectations are, but these are precisely the payers that are most easily gouged by the alleged fraud, because they have no idea. They are just -

744

- they just -- they assume, well, AWP is what Medicare is using. 95 percent of AWP. I'm -- that seems to be what the government is doing. They must know what they are doing.
So there is going to be people with no expectations. It is like someone walking into a car dealer and seeing what the sticker price is and saying, "Well, okay, I will take it at that, I'm not going to negotiate it with you," doesn't look up on Carfacts, doesn't do any research. I read this as an uninformed payer that -- this doesn't mean that there is not a set of relationships that inform the market. This just means that there is one person that is not aware of it.
MR. EDWARDS: I will mark as Exhibit Hartman 029 a copy of the deposition transcript of Thomas E. Greenbaum taken on January 14, 2005.
(Deposition transcript of Thomas E. Greenbaum taken on January 14, 2005 marked Exhibit Hartman 029 for identification.)
A. You know, I would like to follow up with

745

just one further response on this previous exhibit.
You know, the -- it says that he is currently director of provider networks, but again we are pulling out -- you are pulling out one page of this fellow's deposition. I have no idea whether this is the person, you know, someone who is director of provider relationships, or provider networks, whether he is the person doing the negotiations. This doesn't really tell me what this entity, this payer, you know, unless I know this is the guy that is negotiating, you know, there is many a management person that is sitting there director of something and the details are left to somebody else.
So in addition to this person, whether he knew or not and whether he was being gouged or not, he may not be -- they may have a very good idea, this entity, of what the acquisition cost is. This person doesn't (pointing to Exhibit Hartman 028). He may not be the person who is going to know anything about that.

746

Q. Do you know how Mr. Brown was chosen as a witness?
A. My guess would be that he was designated in response to a 30(b)6 that said, "We would like to speak to somebody who knows about reimbursement rates."
Q. It says, "Please produce the person most knowledgeable about this subject."
A. Um-hmm.
Q. Is that consistent with your understanding?
A. I have not --
MR. SOBOL: Objection to the form of the question.
THE WITNESS: Yes.
A. I have not seen -- I have -- I have been on the requesting end of many 30(b)(6)s where I have asked for a person in that context and gotten someone who didn't know what it was, but I -- I would assume you have asked for somebody who did know.
I don't know whether this person -- I

747

don't -- I would have to read this fully to establish his bona fides to establish whether he really does know.
Q. Blue Cross/Blue Shield of Mississippi is a class member in this case; correct?
A. I would assume so.
Q. These are the people that Mr. Sobol represents; correct?
A. The -- Mr. Sobol represents the third-party payers and the beneficiaries, the class as it is defined.
Q. They are the people who are alleging that these defendants should be held liable and should be required to pay money; correct?
A. They are -- they are one of the -- one of the subclasses. They are subclass 2 and part of subclass 3. They are not in subclass 1.
Q. So it is certainly not in their interest to bend over backwards to help the defendants here; correct?
MR. SOBOL: Objection to the form.
A. I'm -- it is certainly reasonable to

748

believe that whomever they would produce it would be somebody who would help in this particular -- help in understanding an area where they are a stakeholder. I don't know whether they have or not. I -- that --
Q. I want you to take a look at the transcript of the deposition of Thomas Greenbaum, which we have marked as Exhibit Hartman 029.
(Handing Exhibit Hartman 029 to the witness.)
Q. He is from Cigna. Cigna is a large, sophisticated payer; is that correct?
A. They are a -- they are a large payer. That's true.
Q. I want to direct your attention to the testimony that begins at line 12 on page 75.
A. You know, before I get directed to any testimony, I just want to see who this person is besides his name.
(Pause.)
(The witness viewing Exhibit Hartman 029.)

749

Q. Take a look at page 6, line 9. "I'm the chief operating officer of CIGNA pharmacy."
A. Okay. I just want to look at kind of his background a bit here.
(Pause.)
(The witness viewing Exhibit Hartman 029.)
A. So this is -- I mean I am looking at a little bit more of his background, and it -- it sounds like Brownie of FEMA. I mean I go to the bottom of page 8, and it says -- or I am sorry -- of 6 and 7 -- "Can you tell me in broad terms prior to coming to Cigna three years ago about your employment background?"
"I worked as a general manager of the Book of the Month Club. Prior to that I was chief operating officer of Marvel Entertainment and prior to that I worked for an entertainment products company in Wisconsin."
So it would be correct to say that prior to coming to Cigna three years ago you had not previously worked in the healthcare insurance

750

industry; is that true?
Okay. So conditioning that on that person's understanding of this industry, what is it that you want me to look at?
Q. Well, when you compare this person to Brownie of FEMA, what did you have in mind? Are you trying to infer that this person is somehow incompetent?
A. No. I am saying that as with, I think, Mr. Brown's bona fides were that he had been head of the Arabian Horse Society prior to being placed as head of FEMA, and that that experience did not give him a nuanced deep understanding of what was necessary for the job into which he was placed, and I -- so I look at this, and I see that someone does not have a -- I mean he is the COO of Cigna, but I'm not seeing a long history of understanding the nuances of all that is -- Cigna is a big company, and it is doing -- it is doing reimbursement for physicians and for hospitals, it is doing all kinds of information management, and along with prescription reimbursement and

751

reimbursement for physician- administered drugs, and I just wanted to see what -- this is a background that doesn't argue a nuanced deep understanding to me, but, and I just wanted to get that in the record. I just wanted to know what his background was.
Q. Well, is it your testimony that to the extent that any payer claims it was injured here it is because they were not competent, like Brownie here?
A. No. It is my testimony that there -- there were -- there were expectations in the market, and there were -- that -- that essentially those expectations that developed in the late '80s, early '90s, relative to these particular drugs, physician-administered drugs, and the relationship of AWP to acquisition costs of the providers was set in Medicare's mind and in third-party payers' minds in the early '90s, and they changed very slowly, and people weren't aware, weren't aware of all of that.
And so the -- it is -- it is very easy

752

for even knowledgeable third- party payers that haven't -- are not paying attention to this one particular aspect of things, where this is an area that can be abused easily by manufacturers, as we see in the Vincasar matter that I cited earlier in my report in the paragraph that quotes Medpac or that were exploited in the Lupron matter. These were -- these were drugs and these were reimbursement rates that were low on the radar screen in Professor Berndt's nomenclature, and so someone that is relatively well informed would not notice the abuse of this spread, and certainly someone who has little background in it is easily duped or could be -- the alleged fraud would be particularly easy to impose upon someone -- a payer like this if this is the person negotiating reimbursement rates.
Q. So it is your testimony that Cigna was duped?
A. It is my testimony as I read -- you have put a deposition in front of me. I am looking at the background of the person, because you are

753

asking me a question about what he knew, and I am looking at his background, and I see that his background suggests to me that he hasn't spent a lot of time studying this market to know that much, and that's all I am saying.
And so --
Q. Take a look at page 75 beginning at line 12.
(Witness complying.)
Q. And this is part of a question:
"Would the same statement that you just made hold true for the actual acquisition cost, that Cigna does not have an expectation of a relationship between average wholesale price or actual acquisition cost but in fact those are two separate pieces?"
And then there are a series of objections.
"Answer: Yeah. I mean I think that our acquisition costs are separate from AWP, and we don't have any expectations of what the relationship is between what we purchase the drug

754

for and what AWP is."
Now given that testimony, do you think that your opinion that payers have expected that AWP is larger than ASP by a reasonably predictable amount simply doesn't apply to Cigna?
MR. SOBOL: Objection to the form.
A. I'm saying -- I am saying that the expectations that I have framed and analyzed and put forward in my report summarize the market as a whole for those -- for those groups who have been surveyed, for those payers for which contracts have been negotiated, and there are going to be -- I would like to see Cigna's contracts with -- with -- with an oncology group to see what was actually negotiated.
The -- you know, I am seeing -- I am sorry. I was trying to see whose all of these names here were.
This is a person who I would assume when negotiating contracts -- this is a senior person that is not close to those details given his background and given the response.

755

So this -- this is again -- has no evidentiary value that I see really even about what Cigna was doing or what Cigna knew.
Q. So are you saying that when you summarize expectations in the marketplace you ignore all evidence that is contrary to your hypothesis?
MR. SOBOL: Objection to the form.
A. No. I seek evidence wherever I can get evidence of someone knowledgeable about what it is I'm analyzing, and from what I see here, this deponent has little credibility as to an understanding of what expectations were, relations were, period.
Q. I want to show you the deposition of Jill Herbold taken January 14, 2005, which I will mark as Exhibit Hartman 030.
(Deposition transcript of Jill A. Herbold taken on January 14, 2005 marked Exhibit Hartman 030 for identification.)
MR. EDWARDS: And I apologize to anybody who might listen to the audio of this deposition

756

for constantly coughing on the record. I just can't help it.
THE WITNESS: Can I offer you a Halls?
MR. EDWARDS: Maybe at the break.
BY MR. EDWARDS:
Q. You said --
A. Could I just take a second, if you would bear with me?
(Pause.)
(The witness viewing prior exhibit.)
A. I just want to review one of the prior exhibits that you had put before me.
(Further pause.)
(The witness continues to view prior exhibits.)
A. Okay. I am sorry.
Q. Now you testified a moment ago when I was asking you questions about Mr. Greenbaum that you would like to see Cigna's contracts in order to evaluate his testimony about the relationship between AWP and ASP; correct?

757

A. And I -- I think you have been very good in finding me a person who might help in that regard.
I did say that. Yes.
Q. I take it you have never asked plaintiffs' counsel to provide you with copies of Cigna's contracts, have you?
A. I have asked for contracts, and I forget what was provided. It is my recollection that we did not receive -- I did not receive a lot of contracts. I certainly relied on some contracts that were put forward by Mr. Young, but I did ask for contracts. I didn't -- I don't think I received any, but I would have to look. I can't recall.
Q. Well, you identify contracts for physician-administered drugs that you rely on in attachment C --
A. I do, yes.
Q. -- to your declaration; correct?
A. That's correct.
Q. And basically you identified four